Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-08-1536-01

MFDR Date Received
June 11, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c) (6) (A)"

Amount in Dispute: $39,510.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2006 to September 7, 2006	Hospital Inpatient Services	$39,510.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of services not identified in an established fee guideline.
4. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-

43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z585 – THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE. (Z585)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - Z695 – THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE. (Z695)
   - Z711 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE CUSTOMARY CHARGES BY OTHER PROVIDERS FOR THIS SERVICE. (Z711)

Findings

1. The insurance carrier denied or reduce payment for disputed services with reason codes Z585 – "THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE;" Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE;" Z695 – "THE CHARGES FOR THIS HOSPITALIZATION HAVE BEEN REDUCED BASED ON THE FEE SCHEDULE ALLOWANCE;" and Z711 – "THE CHARGE FOR THIS PROCEDURE EXCEEDS THE CUSTOMARY CHARGES BY OTHER PROVIDERS FOR THIS SERVICE." The respondent did not explain or submit documentation to support how it determined an amount of reimbursement that was fair and reasonable for the services in dispute. The respondent did not explain or submit documentation to support that a fee schedule is applicable to the services in dispute. No documentation was found to support that the charges for the services in dispute exceed the customary charges by other providers for the same services. The insurance carrier's reasons for reduction or denial of payment are not supported; therefore, the services in dispute will be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that "When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9)." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 840.7. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, Volume 31 *Texas Register*, page 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(B), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute

involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c) (6) (A)."
- The Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute. Per §134.401(c)(5)(A), when ICD-9 codes 800.0-959.50 are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Therefore, the applicable rule for reimbursement is found under §134.1(d).
- The requestor asks for reimbursement under the stop-loss provision found in former 28 Texas Administrative Code §134.401(c)(6). However, §134.401(c)(6) states that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a diagnosis code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to §134.1.
- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

  > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

  Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

	Grayson Richardson	February 8, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.